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AUTHOR Fisher, Lawrence; And Others
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ABSTRACT

An investigation was conducted to assess parental and family characteristics of boys who displayed competence when exposed to a set of stressful circumstances expected to impair and/or retard their development. Participating children and families were involved in the University of Rochester Child and Family Study, a prospective developmental project in which one parent had been hospitalized for psychiatric disorder. Competence in 7- and 10-year-old boys was defined by scores on a combined teacher and peer index and a parent rating of child behavior. In this paper, the first of two describing this study, details of the sample, the pathology of the hospitalized parent (in this instance, the mother), and the construction of the child's competence scores are described. Five hypotheses regarding the relationship between parental or family characteristics and competence are articulated. Specifically, it was hypothesized that (1) children with adequate competence scores would come from families in which the hospitalized adult had an affective disorder and low levels of chronicity; (2) a balance of family warmth and activity level would be related to child competence; (3) a parental first admission late in the child's life would be associated with higher child competency scores; and (4) in its effect on competence, present age of child would interact with chronicity of disorder and age of child at parent's first admission. (Author/RH)

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COMPETENT CHILDREN AT RISK: THEIR PARENTS AND FAMILIES:

1. DESCRIPTION OF STUDY AND MEASURES

Lawrence Fisher, Ph. D. and Ronald F. Kokes, Ph. D.

Veterans Administration Medical Center,

Fresno, California

University of California,

San Francisco

Robert E. Cole, Ph. D., and Patricia M. Perkins, M.D.

University of Rochester School of Medicine

David W. Harder, Ph. D.

Tufts University

Lyman C. Wynne, M.D., Ph. D.

University of Rochester School of Medicine

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The purpose of the following 2 papers is to identify and describe parental and family characteristics of boys who prosper and display competence when exposed to a set of stressful and noxious circumstances that would be expected to impair and/or retard their development. They came from the high risk families examined longitudinally in the University of Rochester Child and Family Study (URCAFS). URCAFS is a programmatic research project comprised of investigators with expertise

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in various aspects of child, adult, and family health and pathology. It is a prospective, developmental study of approximately 145 families in which risk for a child was defined by significant psychopathology in one parent. This pathology was operationally defined as a psychiatric hospitalization. Subject families were identified by a search of records of various inpatient facilities located in Rochester, New York and the Monroe County birth records to identify children fullfilling project criteria. Families were selected who satisfied the following criteria: (1) the hospitalized parent(s) had a functional psychiatric disorder with no evidence of organic brain syndrome and did not have a primary diagnosis of alcoholism or drug abuse; (2) father, mother and children were living together; (3) social class of the family fell within Hollingshead and Redlich's (1954) classes I to IV; (4) the interval between the parent psychiatric hospitalization and project evaluation was at least six months; and (5) the family included a male child 4, 7, or 10 years of age who became the index child for intensive evaluation. The study was limited to male children because the sample size precluded the use of sex of child as a major study variable. Ages 4, 7, and 10 were selected to satisfy the conditions for a convergent longitudinal design, i.e., three year follow-ups of these families would place the children in the successive age groups to which they could be compared agewise.

Following recruitment, the whole family or its individual members spent approximately 40 hours over several weeks being evaluated by the different teams. Assessment procedures included self-report, structured interviews, psychological tests, school evaluation,

laboratory tasks, and clinical observation. Psychophysiological recordings were obtained during some laboratory tasks. The study provided a comprehensive assessment of a range of behaviors which previous research had indicated to be potential contributors to development and outcome in children at risk (Fisher and Jones, 1978). A specific set of these individual and family variables relevant to competent children at risk will be the subject of these 2 papers.

In these reports, competence is defined as the display of successful and mastery behaviors in spite of deleterious circumstances, defined primarily by a psychiatric disturbance of a parent sufficiently serious to warrant his/her hospitalization. Dr. Kokes and I carried out a series of analyses cooperatively to identify characteristics of well functioning children using an extreme groups design and we will present them sequentially in this and in the following report. Only data from families with 7 and 10 year old boys in which the mother was the parent suffering the psychiatric disorder will be presented here because school competence was selected as one of the two major dependent variables to discriminate well functioning from poorly functioning offspring.

The first child competence score was derived from combined teacher and peer classroom ratings. Teacher ratings were obtained from the 35-item Rochester Teacher Rating Scale. Male students were rated on cognitive competence, social compliance, social competence, and motivation. Such ratings were then standardized on same sexed classmates. Similarly, peer ratings were obtained from the Rochester Peer Rating Scale, a 25 item sociometric procedure in which children

are selected for roles classified as brightness/compliance, intrusiveness, friendliness and dullness. Methods of development and standardization of these scales have been presented elsewhere (Fisher, 1980). Summary Teacher Rating Scale and Peer Rating Scale scores were combined into a Grand Teacher Peer Score (GTP) which reflected child functioning at school on a global level.

For purposes of the present report, well functioning boys at risk were those with competence scores at or above 0.5 standard deviations from the mean of same sexed classmates. Likewise, poorly functioning boys were those with competence scores 0.5 standard deviations at or below the mean of same sexed classmates.

The second child competence score was based on parent ratings of child behavior at home using the Rochester Adaptive Behavior Inventory or RABI. The scale is based on age appropriate developmental criteria developed by Jones (1977) and statistically analyzed by Prentke, Fisher and Cipro (1982); and consists of 71 items on which the parents, usually the mother, rated the child. Items related to school behavior or academic functioning were omitted. The scale yields three statistically derived dimensions based on 12 rational factors; social interaction, fearfulness-somatization and motivation-obsessiveness. These three were combined into a global measure of parent rated child competence and standardized by child age. Competence was defined as scores at or above 0.5 standard deviations from the mean and incompetence at or below - 0.5 standard deviations from the mean.

The variables on which these 2 groups of competent and incompetent children at risk were compared were mother/patient diagnosis and

functioning, chronicity of mother's illness, family interaction, age of child, and age of child at parent's first significant episode of mental illness.

Ratings of parents' current and past psychiatric symptomatology, psychological functioning, social and occupational functioning, and chronicity of illness were obtained from structured interviews using the Psychiatric Assessment Interview and the Psychiatric Social History, which were used and refined in the WHO International Pilot Study of Schizophrenia. Parent diagnosis was established by a panel of experienced clinicians utilizing all collected data and information from hospital charts. DSM-III criteria were utilized (Table 1). Of the 145 parent patients, 18 (12%) were schizophrenic, 27 (19%) were bipolar affective psychotic, 11 (8%) major psychotic depressives, 11 (8%) schizoaffective, 31 (21%) were major non-psychotic depressives, and 8 (5%) non-psychotic bipolar affective disorders and 8 (5%) were anxiety disorders.

Parents' social and work functioning were each rated on a scale of 0, indicating poor functioning, to 4 reflecting excellent functioning. A chronicity of illness rating scale developed by Dr. Patricia Perkins was used by the parent assessment team of URCAFS to establish chronicity of illness scores for the patient and spouse. Scores ranged from 1 indicating a single episode of psychiatric illness with a full recovery to 6 indicating chronic moderate to severe psychiatric symptoms with or without acute episodes for at least two years prior to the assessment. Ratings of 5 and 6 were considered high levels of chronicity. Mean chronicity of mother/patients was 4.02.

The selected set of family interaction variables chosen for analysis were generated utilizing data from an unstructured family task developed by Alfred and Clara Baldwin and Robert Cole. The father, mother and index child were observed in a free play setting in which the parents were encouraged to interact with their child as they would at home if they had an uninterrupted half hour. Interaction scores were generated by computer from verbal descriptions narrated by trained observers. For our analysis, we chose an index of balance and warmth of activity rated for each dyad of the family, i.e., father-child, mother child, and combined parents-child. These balance and warmth scores reflected at least moderate rates of interaction initiated relatively equally by each dyad member with each member communicating, at least, moderate warmth in the interchange. A complete description of the procedures and scoring methods is presented in Cole et. al. (1979).

The hypotheses to be tested were as follows:

I. Mothers with affective diangoses will have higher competence offspring than will mothers with a nonaffective diagnosis. This relationship is hypothesized based on the established relationship between affective symptomatology and positive outcome in mental illness.

II. Mothers with low levels of chronicity will have more competent sons than chronically ill mothers. It seems reasonable to assume that continued exposure to a mother's illness is more damaging than exposure to a circumscribed and limited episode.

III. Balance and warmth in parent/child interactions will be

positively related to child competence. Such interactions imply a communication pattern allowing exchange of information and feelings promoting increased knowledge and emotional growth.

IV. Mothers whose illness occurred later in their child's life will have more competent sons than mothers whose illness began prior to their son's birth or early in their son's lives. Children at earlier developmental levels are more vulnerable because they do not have the personal resources or the availability of outside resources to resist the effects of their mother's illness.

V. Present age of child (7 or 10) will interact with chronicity of parental disorder and child age at mother's first episode in their effect on child competence.

ABSTRACT

In this paper, we describe the parental and family characteristics of boys who prosper and display competence when exposed to a set of stressful and noxious circumstances that would be expected to impair and/or retard their development. The children and families come from the University of Rochester Child and Family Study, a prospective developmental project in which one parent was hospitalized for psychiatric disorder. Child competence in seven and ten year old boys was defined by two scores: a combined teacher and peer index and a parent rating of child behavior. In this paper, details of the sample, the pathology of the hospitalized parent and the construction of the child's competence scores are presented. In addition, five hypotheses regarding the relationship between parental or family characteristics and child competence are articulated: children with adequate competence scores will come from families where the hospitalized adult had (1) an affective disorder and (2) low levels of chronicity; (3) a balance of family warmth and activity level will be related to child competence; (4) a parental first admission late in their childs' life will be associated with higher child competence scores; and (5) present age of child will interact with chroncity of disorder and age of child at parent's first admission in its effect on child competence.